



# Issues Faced by Community Health Centers

JANE GROVER, DDS, MPH

**ABSTRACT** Federally qualified health centers face numerous issues with regard to marketplace competition, staffing, and reimbursement streams that assure financial viability. Positioning the dental department of a health center to a high community profile strengthens the health center in professional educational development leading to a pipeline of workforce members, effective dental directors, and innovative fund-raising. A new dental team member developed by the American Dental Association can be utilized in health centers to make all traditional auxiliaries more productive.

## AUTHOR

**Jane Grover, DDS, MPH**, is a dental director, Center for Family Health, in Jackson, Mich., immediate past first vice-president of the American Dental Association and current ADA consultant on health centers.

**D**ental directors of federally qualified health centers face significant challenges in treating a large population with multiple dental needs and financial restrictions. These issues have no easily known remedies posing rapid resolutions: They are more like dilemmas, having no final solution but requiring some innovative operational strategies.

### Professional Relationships and Stature

A major problem reported by dental directors of federally qualified health centers in a recent survey was the feeling of professional isolation.<sup>1</sup> The sharing of clinical success and failure is difficult to address if no time is built into the dental director's schedule to actively partake in the company of other dental practitioners with

similar types of patients. It is particularly necessary to do, especially when treating a significantly sized financially disadvantaged population with dramatic disease.

Networking with other dental directors is a most valuable activity. This is the main way to find relief in the knowledge that many oral health program directors face similar issues. Visioning effective strategies to cope with what can feel like a continuous flow of disease is best accomplished with a team approach. Many new dental directors report faster acclimation to their environment by interacting with more seasoned directors. Proactive health center executive directors could realize cost savings in this exercise, as problems, which seem overwhelming to their new dental directors, have been faced and solved by the more experienced ones.

Many state primary care associations do not formally construct personal networking opportunities for dental directors like they do for medical directors. It is up to the leaders of each state to make this happen, or meet at the National Primary Oral Health Care Conference meeting convened each year by HRSA through the National Network for Oral Health Access.

One major issue facing CHC dental programs, which can escalate the feeling of isolation of the dental director, is the climate of misconceptions that often arise from the private practice dental community, other health providers, or the public in general about the services that are offered to patients.

Oral health programs that begin in a CHC often open their doors without widespread local knowledge in the dental community. Some practitioners may even doubt the need for these services and doubt the levels of unmet need.

As a result, many new programs have local dentists expressing a fear of “losing patients” to the health center from their private practices. They also may hear dental office gossip about the health center and create distress in the dental community about the dental director.

Fear that the health center *could* become a closed panel of providers for the local hospital or a local manufacturing plant, thus putting the private practitioners out of business, can be well managed by using the best sociological tools possible: information and time.

Being a member of the local dental society gives a CHC dental director the opportunity to dispense accurate information. A health center’s federal grant requirements, service area, scope of services and populations of focus are examples of what can be delivered on an informal basis monthly at the local constituent meetings.

Formal programs including a PowerPoint presentation given yearly to the local dental society displaying statistics, payer mix, and several photographs added in for those who doubt the existence of rampant decay in any community, send a powerful message, especially during February, which is recognized as Children’s Dental Health Month.

Some health centers have had success in linking the local dental provider population by having a prominent local



dentist serve on the board of directors of the health center. This person can frequently serve as an ambassador to the dental community. Other centers have had success by developing a dental advisory committee.

Hosting the local dental hygiene society at the health center dental clinic for one of their official monthly meetings is another tactic to combat local misinformation. Providing updates on current activities helps spread the mission/vision of the center. Most attendees will be excited to go back to their offices to transmit this information to the dentists they work with. Many health centers develop an impressive volunteer force from this simple strategy.

Dental directors who write a yearly update for the local newspaper raise the

community profile of their programs by informing the whole community of what the dental clinic achieved during the previous year. Providing data on the number of patients seen, the most utilized services, and how the local physicians can assist with medically integrated care for dental patients establishes the health center as a hub for community care.

Multiple layers of public relations information lead to professional transparency and the building of pride in the dental department. This usually leads to a climate of trust and support by a collateral community that may have been very skeptical of the health center dental program in the beginning stages.

Dental directors would be wise to utilize all forms of media in educating the community. Walking into the studio of the local disc jockey who does a daily live talk radio show gives the valuable opportunity to update the listening audience on the latest dental information, from the oral health-systemic health connection to the important first oral exam for establishing the dental home. Local television stations, anxious to increase viewer ratings with health information, are also good opportunities for dental directors to highlight their health centers and programs.

Another point to remember in local talk radio: Legislators have staff whose job descriptions entail listening to these types of shows and reporting what they heard. This becomes an efficient way for health centers to promote their activities to legislators (FIGURE 1).

### Workforce

Perhaps no other issue that a health center faces is more critical than workforce. Oral health professionals must continually look over their shoulders to hear footsteps of who will come

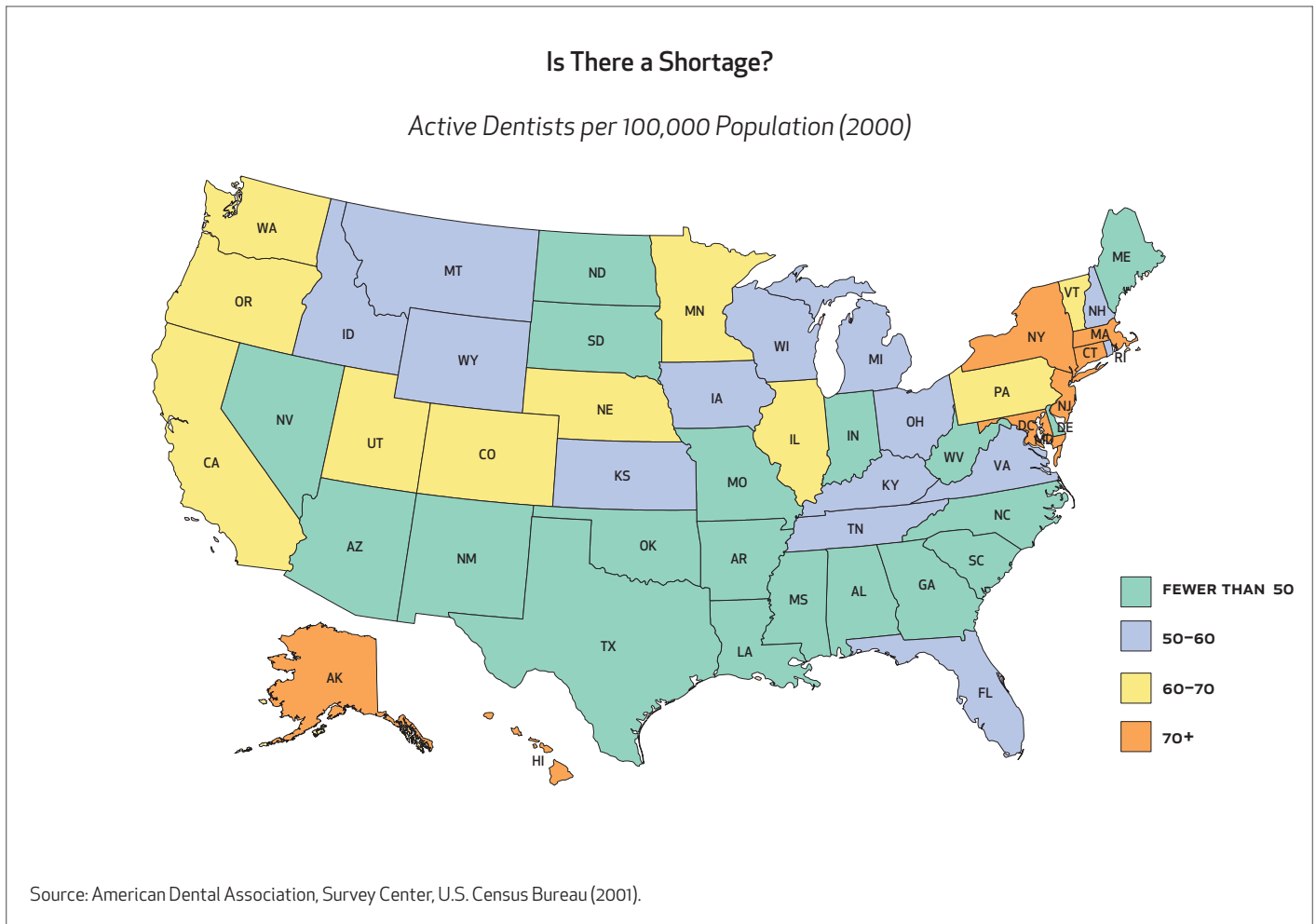


FIGURE 1.

after the current workforce retires.

Having a high community profile is one key to attracting personnel. Statistics tell us that only 2 percent of the nation's dentists work in health centers. If the number of health centers is to double in the next 10 years, as some predict, from where will the dental staff come?

Having dental residents and students from local dental schools is a valuable way to achieve a pipeline of dentists. Part of dental education in the future has to involve health centers, which can provide experience, loan forgiveness, and a keen perspective on public health. The dental school A.T. Still in Arizona certainly personifies this. More dental schools are set to open within

the next two years and many current schools have outreach programs as part of the undergraduate curriculum.

The actual number of practicing dentists is supported by data, but that data does not tell us which dentists treat patients 40 hours per week, or 20 hours per week. Whether or not there is a shortage of dentists remains a hotly contested topic of debate. The primary focus should be on health centers to recruit and retain dentists with adequate salary packages, perhaps to the level that physicians working at health centers receive at present. Health centers in rural areas are particularly vulnerable to workforce demands and should actively recruit dentists, or contract with local private practitio-

ners to provide care (FIGURES 2 AND 3).

Strategies to eliminate decay and reduce oral health disparities must involve a team, not just more dentists. This is one reason that the ADA has designed a new member: the community dental health coordinator.

The ADA House of Delegates has continued to support the CDHC, both in funding and curriculum development, by a vote of more than 80 percent. Sites have been selected to pilot this program and the value of this new team member cannot be overemphasized.

With a one-year term of classroom training and on-job rotations through community health center dental departments, the CDHC will do some tasks

that dental staff currently struggle to perform. Coordination of care, navigation of care, and community education are just a few of the duties of the CDHC. Some executive directors are ready to hire them now and the pilot programs have not even been completed yet.

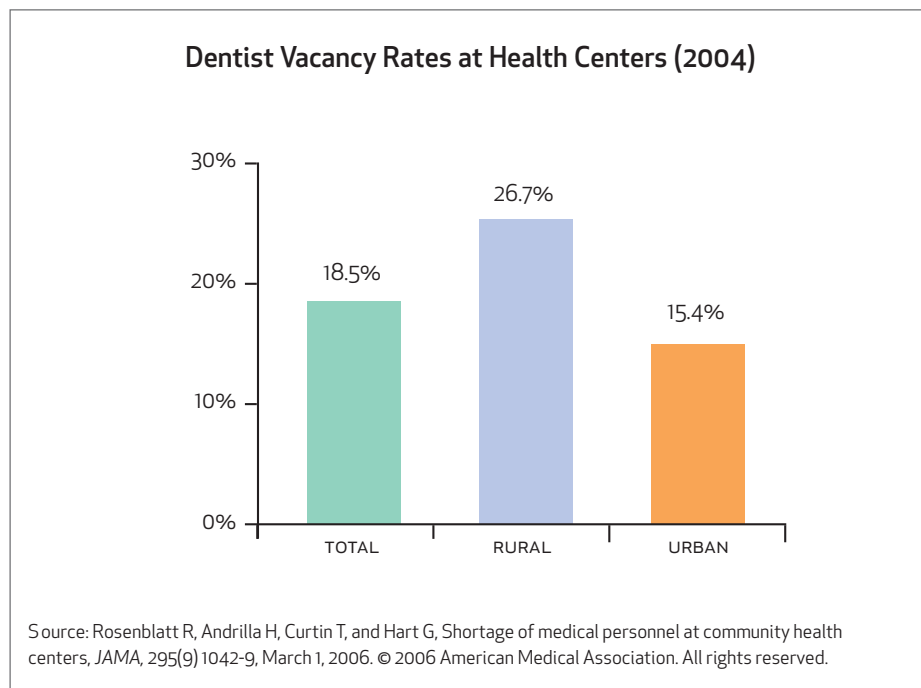
Some believe that dental assistants can do these functions. The majority of assistants, however, are needed to perform their expanded functions and assist chairside. Sending dental assistants to the Women, Infants and Children program in an attempt to educate that agency's staff about the carious process, the county school nurses meeting, the school board meeting and other community meetings to promote oral health does not make the dentists of a health center more productive.

Dental hygienists provide their professional value on hygiene services for the health center: not focusing on broken appointments, screening kids at school health fairs, and scheduling specialty appointments. Chairside efficiency and productivity are the major incentives for dental hygienists, particularly when preventive services remain the most highly reimbursed of state insurance plans. The CDHC would provide valuable information to the clinical time expectations of the dental hygienist and reduce their professional stress.

The CDHC can help all dental providers be more efficient, reduce no-shows, help link the underserved to continuing care. This culturally competent auxiliary will be similar to the promotoras (community health workers) in California who are so effective at working with families to provide oral health education and promotion.

### Funding Challenges

A critical issue for community health centers is funding. Financial strength can give a dental department significant



**FIGURE 2.**

professional leverage and high community profile in treating the underserved.

The major source of health care coverage for almost 40 percent of the average FQHC population is Medicaid.<sup>2</sup> Most states report a low participation rate in Medicaid among private practice dentists. As a result, most dental programs in FQHCs depend on Medicaid revenues for financial sustainability. These dental programs in FQHCs also are the only treatment source for the uninsured that can also link these patients to medical services for comprehensive health care.

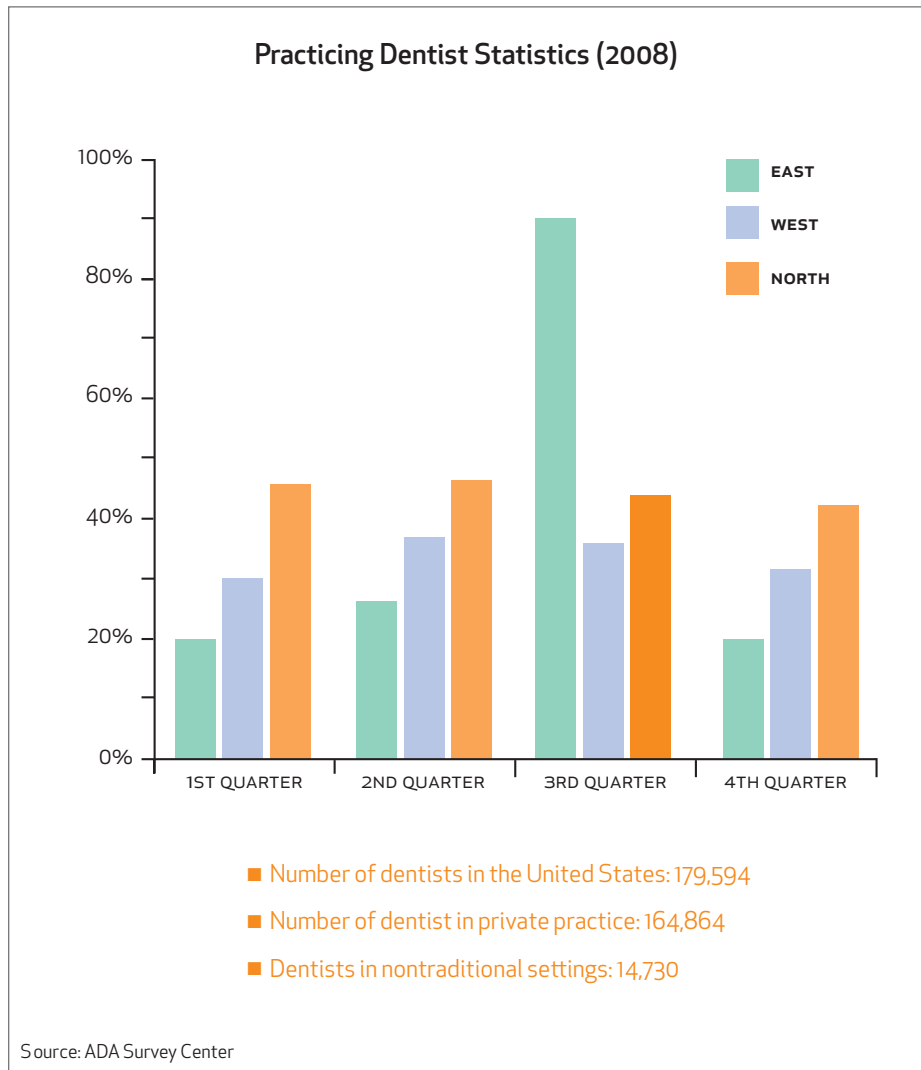
This uninsured growing segment of the population can place a strain on the financial viability of the health center dental department, which has inherently higher costs of delivering care than the medical side. Equipping and maintaining a dental operatory involves significantly more funding that may be poorly understood by administration. Dental directors must be active as well as creative in partnering with community groups who can provide a financial stream to offset losses, which occur in treating the uninsured in

a climate of unpredictable state budgets.

Typically, health center dental departments depend on state Medicaid reimbursement mechanisms, including negotiated “wrap-around” payments to supplement on a quarterly basis what is “written off” as bad debt. Utilizing these cost-based reimbursement monies, along with the annual federal grant helps cover many, but not all, costs.

Every community has influential groups and individuals who are opinion leaders within organizations with expendable resources. Many organizations actively look for worthy projects to support. The opportunities are remarkable, if the right parties are involved.

A logical place to begin is with the service groups. The Rotary, Kiwanis, and Lions clubs are built upon membership, which may include retired dentists, dedicated to serving the community. An invitation to present a program on what dental needs exist in the community often prompts the question, “How much do you need for a new dental chair or mobile dental unit?”



**FIGURE 3.**

One dental director found herself invited to a prominent social tea where 300 women in attendance wanted to hear about children's oral health in the community. This dentist was pleasantly surprised when they all took out their checkbooks and made a total group contribution of \$13,000 to the health center dental clinic.

Financial support must come to health centers in a variety of ways. In this day and age, health centers must be ready to engage any community group, local foundation, or civic-minded philanthropist to supplement revenues. Some health centers having wine tast-

ings, silent auctions, and other creative events to raise awareness and funds for oral health programs. The relationships formed by these events are of permanent benefit to the health center.

### Summary

The highlighted issues here are only a few of the ones facing community health centers today. More surveys and studies are needed to identify and prioritize others. The recently passed stimulus package (The American Recovery and Reinvestment Act) from the federal government calls for dramatically

increased funding for health centers and the opening of 126 new sites. Becoming familiar with this system of care would be of benefit to all dental providers.

With a positive outlook and community team support, health centers can face their best days ahead. Promoting preventive strategies and reducing disease, enhancing oral health education, and establishing dental homes can enable health centers to cope with these issues and thrive — not just survive. ■■■■

### REFERENCES

1. Diring JD, Phipps K, Expanding access to dental care through California's community health centers. *J Calif Health-Care Foundation*, August 2008.
2. Health centers as safety net providers: An Overview and assessment of Medicaid's role, National Association of Community Health Centers Fact Sheet, add No. 0208. NACHC, 2004.

### TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE

**CONTACT** Jane Grover, DDS, MPH, 2298 Springport Road, Suite B, Jackson, Mich., 49202.